DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445427	A. BUILDING _____ B. WING _____	06/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HEALTH CARE CENTER	444 ONE ELEVEN PLACE COOKEVILLE, TN 38501

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F 000	INITIAL COMMENTS Complaint investigation #'s 23170 and 25680, were completed on June 15-17, 2010, with the annual Recertification survey at Bethesda Health Care Center. No deficiencies were cited under 42 CFR Part 483.13, Requirements for Long Term Care related to the Complaint investigations.	F 000		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide services to maintain Range of Motion for one resident (#3) of twenty-two residents reviewed. The findings included: Resident #3 was admitted to the facility on November 14, 2006, with diagnoses including Cerebral Vascular Accident, Muscular Dystrophy, Tracheostomy, and Rheumatoid Arthritis. Medical record review of the Minimum Data Sets dated August 27, 2009, November 17, 2009, and February 11, 2010, revealed the resident had limitations of the leg (including hip and knee and	F 318	483.25 (c) (2) **Increase/Prevent Decrease in Range of Motion** SS=D Requirement: The facility will ensure that residents with a limited Range of Motion will receive appropriate treatment and services to increase and/or prevent further decline in range of motion. Corrective Action: 1. Resident #3 was referred to therapy services on 6/15/10 for decline in Range of Motion. The care plan was updated to reflect the current treatment. 2. Charts were reviewed on 6/23/10 by nurse management to identify residents with a decline in Range of Motion. Nursing staff to communicate potential decline, CNA's to charge nurse, charge nurse to therapy, so as to have residents screened timely. 3. In-services held on 6/23/10, 7/16/10, and 7/19/10 with nursing staff by the DON regarding the procedure for referring residents with a decline in Range of Motion to therapy services for screening. 4. The Risk Management Nurse or designee will monitor compliance monthly during random medical record reviews and observations.	7/19/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 7/19/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 318	Continued From page 1 the foot) (including ankle or toes) on one side with full loss of voluntary movement. Medical record review of the Minimum Data Set dated May 1, 2010, revealed the resident had limitations of the leg (including hip and knee) and the foot (including ankle or toes) on both sides with full loss of voluntary movement. Medical record review of the care plan updated May 1, 2010, revealed no interventions to address Range of Motion. Medical record review revealed the resident was not currently receiving any therapy services. Observation on June 15, 2010, at 3:10 p.m., with the Minimum Data Set Nurse confirmed the resident had limitations to the leg and foot on both sides more on the left side than the right side. Interview with the Minimum Data Set Nurse at 3:15 p.m., at the 300 hall Nurse's station, confirmed the resident's Range of Motion was as reflected on the Minimum Data Set dated May 1, 2010, and indicated a decline in Range of Motion. Continued interview confirmed therapy is to be notified when a change is noted and therapy had not been notified of the decline in Range of Motion. Further interview confirmed the resident's care plan did not have any interventions to address the decline of Range of Motion. Interview with Certified Nursing Assistant #1 on June 16, 2010, at 8:45 a.m., at the 300 hall Nurses Station, revealed the only Range of Motion provided was during showering, transferring, and dressing the resident.	F 318		

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F 318	Continued From page 2 Interview with the Nurse Practitioner on June 16, 2010, at 9:00 a.m., at the 300 Nurse's station, confirmed the decline in Range of Motion would be a natural progression with a history of Cerebral Vascular Accident and Muscular Dystrophy. Interview with the Director of Nursing on June 16, 2010, at 2:00 p.m., in the Director of Nursing office, confirmed the resident had a decline in Range of Motion as per the Minimum Data Set dated May 1, 2010. Continued interview confirmed when a decline is noted in Range of Motion therapy is to be notified to screen and / or evaluate the resident. Continued interview confirmed the resident was not evaluated by therapy until June 16, 2010. Further interview confirmed the resident's care plan updated May 1, 2010, did not include any interventions to address the resident's decline in Range of Motion. Interview with the Physical Therapist on June 17, 2010, at 8:30 a.m., in the conference room, confirmed a restorative program would be required for the resident to maintain and or delay the progression of a loss in Range of Motion, and the resident did not have a restorative program in place prior to evaluating the resident on June 16, 2010.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	483.25 (h) Free of Accident Hazards/Supervision/ Devices SS=D <u>Requirement:</u> The facility will ensure that the resident environment remains free of facility hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a safety device was in place for one (#10) of twenty-two residents reviewed. The findings included: Resident #10 was admitted to the facility on August 24, 2009, with diagnoses including Dementia, Congestive Heart Failure, Hypertension, and Hypothyroidism. Medical record review of the Minimum Data Set (MDS) dated February 10, 2010, revealed the resident had short term memory problems, required extensive assistance with transfers, and had fallen in the past thirty days. Medical record review of the Fall Risk Assessments dated February 8, 2010, and April 1, 2010, revealed the resident was at high risk for falls. Medical record review of a Nurse's Event Note dated January 9, 2010, at 12:30 a.m., revealed the resident experienced a fall from the bed without injury. Medical record review of a Care Plan / Comprehensive Assessment Review note dated January 9, 2010, revealed a bed alarm was to be placed on the resident's bed when available. Medical record review of the Plan of Care dated November 23, 2009, February 11, 2010, and May 4, 2010, revealed the resident was at increased risk for injury from falls, and on January 9, 2010,	F 323	Corrective Action: 1. The bed alarm was applied to the bed of resident #10 on 6/16/10 by the DON. 2. An audit was conducted 6/16/10 by nurse management to ensure safety devices ordered were in place. 3. The nursing staff was in-serviced on 6/23/10, 6/16/10, and 6/19/10 by the DON on ensuring safety devices are implemented as recommended/ordered. 4. The Risk Management Nurse or designee will monitor compliance of safety devices monthly during facility rounds and observations. Risk Management Nurse will conduct random audits with nursing staff to ensure knowledge and proper placement of safety devices. Nursing staff to monitor daily for proper placement of safety devices.	7/19/10

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F 323	Continued From page 4 the intervention was added to the Plan of Care to place a bed alarm when available. Medical record review of a Nurse's Event Note dated April 1, 2010, at 12:30 a.m., revealed "Called to room per CNA's (Certified Nursing Assistants) making rounds found sitting on floor @ (at) foot of bed. Awake no c/o's (complaints). ROM (range of motion) to extremities good. No bruises or abrasions...had taken body alarm off...Immediate Steps Implemented to Prevent Recurrence: Bed alarm placed..." Medical record review of a Nurse's Event Note dated June 15, 2010, at 12:20 a.m., revealed "Pt (patient) was attempting to get out of bed and slid down to floor, 'stated my legs got weak and gave out '...no apparent injury..." Observation on June 16, 2010, at 7:55 a.m., revealed the resident lying on the bed without a bed alarm in place. Observation on June 16, 2010, at 2:47 p.m., with the Director of Nursing (DON), of the resident's bed, revealed the DON removed the sheets from the bed and confirmed there was no bed alarm present. Telephone interview on June 16, 2010, at 1:55 p.m., with CNA #2 revealed CNA #2 had found the resident on the floor on April 1, 2010, at 12:30 a.m. Continued interview revealed CNA #2 had provided care for the resident from January through April 2010, and could not remember seeing a bed alarm on the resident's bed. Continued interview confirmed there was no alarm sounding at the time of the resident's fall on April 1, 2010. Telephone interview on June 17, 2010, at 10:05	F 323		

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F 323	Continued From page 5 a.m., with Licensed Practical Nurse (LPN) #3, nurse in charge of the resident's care at the time of the fall on June 16, 2010, confirmed there was no alarm in place at the time of the fall. Interview on June 16, 2010, at 2:45 p.m., with the Director of Nursing (DON) in the DON's office revealed there was no documentation the resident had a bed alarm in place from January 9, 2010, until June 16, 2010.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	483.65 Infection Control, Prevent Spread, Linens SS=D Requirement: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective Action: 1. LPN #1 was removed from the responsibilities of providing treatment care as of June 15, 2010. The nurse also received direct one on one in-service training regarding proper infection control techniques before she was allowed to return to assigned tasks as a medication nurse on 6/16/10 by the DON. 2. The new designated treatment nurse was observed during scheduled treatments to ensure appropriate infection control measures, including hand washing were being followed. 3. Nursing staff was in serviced 6/23/10 by the DON on Infection Control Prevention Procedures. 4. The Risk Management Nurse/designee will monitor for compliance monthly during treatment observation rounds.	6/23/10

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F 441	Continued From page 6 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the staff failed to wash the hands and provide appropriate wound care during a dressing change for one (#1) of twenty-two residents reviewed. The findings included: Observation on June 15, 2010, at 1:10 p.m., revealed Licensed Practical Nurse (LPN) #1 providing wound care to resident #1. Observation revealed LPN #1 washed the hands, applied gloves, removed a soiled dressing from the right lateral ankle area, and described the wound as a Stage III wound with a moderate amount of yellow drainage. Continued observation revealed LPN #1 removed the soiled gloves and without washing the hands, obtained a paper measuring device from the treatment cart, located in the hallway. Continued observation revealed LPN #1 reentered the resident's room, washed the hands and applied clean gloves. Continued observation revealed LPN #1 applied saline to a gauze pad and patted/touched the wound seven times with the same area of the gauze pad. Continued observation revealed LPN #1, without changing	F 441		

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F 441	Continued From page 7 the gloves or washing the hands, applied ointment with a gloved finger to the perimeter of the wound, and applied a dressing with medication, applied a foam dressing, and wrapped the right lateral ankle area with a gauze wrap. Continued observation revealed LPN #1 spilled a small bottle of saline, removed the gloves and wiped the saline from the floor with a wash cloth, and without washing the hands, obtained another small bottle of saline from the treatment cart, reentered the resident's room, placed the saline on a clean drape, and washed the hands. Continued observation revealed the following: LPN #1 applied gloves and removed a dressing from the left lateral foot; removed the gloves, washed the hands, and applied clean gloves; measured and described the wound as unstageable 5.0 cm. (centimeters) X 2.8 cm. with a small amount of brownish colored drainage; applied saline to a gauze pad and patted/touched the wound twelve times with the same area of the gauze pad. Observation revealed resident #1 complained of pain, and LPN #1 removed the soiled gloves, and without washing the hands exited the resident's room, walked down the hallway to the Medication Prep room, unlocked and touched the door handle to the Medication Prep room, and told LPN #2 the resident needed pain medication. Observation revealed LPN #2 crushed pain medication for the resident and placed the medication in applesauce. Continued observation revealed LPN #1, without washing the hands, poured water into a cup from a pitcher located on the medication cart, took the medication prepared by LPN #2, and returned to resident #1's room and administered the pain medication. Continued observation revealed LPN	F 441		

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F 441	Continued From page 8 #1 held a straw for the resident to drink water after administering the pain medication, without washing the hands. Continued observation revealed LPN #1 washed the hands after administering the pain medication and applied gloves. Continued observation revealed LPN #1 applied saline to a gauze pad, patted/touched the wound, on the left lateral foot, four times with the same area of the gauze pad, and without changing the gloves or washing the hands, applied ointment to a soiled gloved finger, and applied ointment to the perimeter of the wound. Continued observation revealed without changing the gloves or washing the hands LPN #1 applied a medicated dressing to the wound, applied a foam dressing, and wrapped the wound with gauze. Continued observation revealed LPN #1 replaced the lid on the ointment with soiled gloves, and then removed the gloves and washed the hands. Continued observation revealed after washing the hands LPN #1 spilled a cola from the resident's table, splashing onto resident #1's dressing on the right foot. Continued observation revealed LPN #1 applied gloves, removed the gauze wrapping, wet with cola, noted the foam dressing under the gauze wrapping was wet with cola, exited the resident's room, without removing the soiled gloves or washing the hands, and opened the treatment cart to obtain clean supplies. Observation revealed LPN #1 removed the soiled gloves, and without washing the hands, proceeded to Central Supply to obtain an additional foam dressing. Observation revealed LPN #1 unlocked the Central Supply room and obtained five foam dressings, without washing the hands, returned to the treatment cart and placed four of the dressings into the treatment cart.	F 441		

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F 441	Continued From page 9 Continued observation revealed LPN #1 returned to the resident's room, washed the hands, applied gloves, and removed the soiled foam dressing from the resident's right foot, washed the hands, applied gloves, and applied the clean foam dressing and gauze. Review of the facility's policy Dressing Changes revealed "...Remove soiled dressing in trash bag. Discard gloves in trash bag and wash hands. Don new pair of gloves. Clean wound per order. Cleanse away from debris and drainage from wound, moving from center outward; use a new pad for each area cleaned, discarding the old pads...Discard gloves in trash bag and wash hands. Don new pair of gloves. Place ordered treatment into wound or onto dressing, as appropriate for type of wound. Dress the wound as ordered...Dispose of gloves and materials and store supplies as appropriate. Wash hands..." Interview on June 16, 2010, at 2:05 p.m., with LPN #1, with the Director of Nursing (DON) present, in the DON's office, revealed the hands were to be washed each time the gloves were removed, and confirmed the hands were not washed each time the gloves were removed and after cleaning the wound on the right foot prior to applying medication or a clean dressing to the wound. Continued interview confirmed the wounds were not cleansed appropriately from the center outward and the facility's Dressing Changes policy was not followed.	F 441		